grouping under paragraph (1).

(3) The average property allowance for each percentile grouping shall be multiplied by a percentage as established by the secretary.

(d) (1) The depreciation component of the property allowance shall be:

(A) Identifiable and recorded in the provider's accounting records;

(B) based on the historical cost of the asset as established in this regulation; and

(C) prorated over the estimated useful life of the asset using the straight-line method.

(2) (A) Appropriate recording of depreciation shall include the following:

(i) Identification of the depreciable assets in use;

(ii) the assets' historical costs;

(iii) the method of depreciation;

(iv) the assets' estimated useful life; and

(v) the assets' accumulated depreciation.

(B) Gains and losses on the sale of depreciable personal property shall be reflected on the cost report at the time of the sale. Trading of depreciable property shall be recorded in accordance with the income tax method of accounting for the basis of property acquired. Under the income tax method, gains and losses arising from the trading of assets shall not be recognized in the year of trade but shall be used to adjust the basis of the newly acquired property.

(3) For depreciation purposes, the cost basis for a facility acquired after July 17, 1984 shall be the lesser of the acquisition cost to the holder of record on that date, or the purchase price of the asset. The cost basis shall not include costs attributable to the negotiation or final purchase of the facility, including legal fees, accounting fees, travel costs and the cost of feasibility studies.

(e) (1) Providers may request a property fee rebasing if the following capital expenditure thresholds are met :

(A) $25,000.00 for facilities with 50 or fewer beds; or

(B) $50,000.00 for facilities with 51 or more beds.

(2) The per diem from the interest or depreciation, amortization, or both, from the capital expenditures, reported in the ownership cost center of the cost report, shall be added to the property allowance per diem originally established. Interest expense reported in the administrative cost center of the cost report shall not be included in the rebasing request.

(3) Resident days used in the denominator of the property allowance calculation shall be based on the total resident days used to compute the rate being paid at the time the property rebasing is requested. The resident days shall be subject to the 85 percent minimum occupancy requirement, including new beds documented in the rebasing request.

(4) The revised property allowance shall be used to determine the property value

factor. The revised property value factor shall be based on the existing arrays. The skilled nursing facility array shall be used for medicare skilled nursing facilities. The nursing facility array shall be used for all other facilities.

(5) Effective dates for rebased property fees:

(A) If new beds are added to a facility because of a construction project, the rebased property fee shall be effective on the date that the beds are certified by the department of health and environment.

(B) If the capital expenditure being rebased is not related to increased numbers of beds , the effective date of the rebased property fee shall be the first day of the month closest to the date upon which complete documentation has been received by the agency. Documentation includes the following:

(i) The depreciation/amortization schedule reflecting the expense;

(ii) the loan agreement;

(iii) the amortization schedule for interest;

(iv) invoices;

(v) contractor fees; and

(vi) proof of other costs associated with the capital expenditure.

(6) A property fee rebasing shall not be allowed if the request and documentation are submitted more than one year after the property subject to the rebasing has been acquired and put into service.

30-10-25 (5)

(f) The effective date of this regulation shall be December 29, 1995. (Authorized by and implementing K.S.A. 1994 Supp. 39-708c, as amended by L. 1995, Ch. 153, Sec. 1; effective May 1, 1985; amended May 1, 1988; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995.)

30-10-27. Central office costs. (a) Allocation of central office costs shall be reasonable, conform to general accounting rules, and allowed only to the extent that the central office is providing a service normally available in the nursing facility. Central office costs shall not be recognized or allowed to the extent that they are unreasonably in excess of similar nursing facilities in the program. The burden of furnishing sufficient evidence to establish a reasonable level of costs shall be on the provider. All expenses reported as central office costs shall be limited to the actual resident-related costs of the central office.

(1) the provider shall report cost of ownership or the arms-length lease expense, utilities, maintenance, property taxes, insurance, and other plant operating costs of the central or regional office space for resident-related activities report as central office costs.

(2) the provider shall report all administrative expenses incurred by central and regional offices as central office costs. These include the following:

(A) salaries;

(B) benefits;

(C) office supplies ;

(D) printing, management and consultant fees ;

(E) telephones and other forms of communications ;

(F) travel and vehicle expenses;

(G) allowable advertising;

(H) licenses and dues; and

(I) legal, accounting, data processing, insurance, and interest expenses.

These costs shall not be directed to individual facilities operated by the provider or reported on any other line of the cost report.

(3) Non-reimbursable costs in K.A.R. 30-10-23a, costs allowed with limitations in K.A.R. 30-10-23b, and the revenue offsets in K.A.R. 30-10-23c shall apply to central office costs.

(4) Estimates of central office costs shall not be allowable.

(b) Central office salary and other limitations.

(1) Salaries of employees performing the duties for which they are professionally qualified shall be allocated to the room and board and health care cost centers as appropriate for the duties performed. Professionally qualified employees include licensed and registered nurses, dietitians, and others as may be designated by the secretary.

(2) Salaries of chief executives, corporate officers, department heads, and other employees with ownership interests of five percent or more shall be owner's compensation and and the provider shall report these salaries as owner's compensation in the administrative cost center.

(3) The provider shall include the salary of an owner or related party performing a resident-related service for which such person is professionally qualified in the appropriate cost center for that service, subject to the owner-related parties salary

limitations.

(4) The provider shall report salaries of all other central office personnel performing resident-related administrative functions in the administrative cost center.

(5) All providers operating a central office shall complete and submit detailed schedules of all salaries and expenses incurred in each fiscal year. Failure to submit detailed central office expenses and allocation methods shall result in an incomplete cost report. The provider shall submit methods for allocating costs to all facilities in this and other states for prior approval. Changes in these methods shall not be permitted without prior approval.

(6) A central office cost limit may be established by the agency within the overall administrative cost center limit.

(7) The provider may allocate and report bulk purchases by the central office staff for plant operating, room and board, and health care supplies in the appropriate cost center of each facility if sufficiently documented. Questionable allocations shall be transferred to the central office cost line within the administrative cost center.

(c) The effective date of this regulation shall be December 29, 1995. (Authorized by and implementing K.S.A. 1994 Supp. 39-708c, as amended by L. 1995, Ch. 153, Sec. 1; effective May 1, 1985; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Dec. 29, 1995.)

30-10-29 (1)

30-10-29. Reimbursement for 24-hour nursing care. Nursing facilities participating in the medicaid/medikan program shall be reimbursed for providing 24-hour nursing care subject to the following limitations. (a) Nursing facilities which are currently providing 24-hour nursing care and whose costs are included in the current payment rate shall not be entitled to additional reimbursement.

(b) Nursing facilities which incur the costs of professional nurses' services for an additional evening or night shift seven days per week, but who do not have these costs included in the facility's payment rate, shall be reimbursed for these costs. Professional nurses may be registered nurses or licensed practical nurses. The additional costs of the nurses include salaries, employer payroll taxes, and related employee benefits.

(1) The reimbursement shall be limited to the evening and night shifts, 16 hours per day, seven days per week. Any provider may request reimbursement for either shift after partial compliance is met or for both shifts after full compliance is met.

(2) A reimbursement factor for 24-hour nursing care shall be provided in addition to a nursing facility's current medicaid rate and may exceed the health care cost center limit.

(3) The per diem factor shall be determined after the nursing facility submits the required forms and documentation.

(4) Required documentation includes copies of payroll records reflecting the names of nurses hired and the nurses' salary costs.

(5) If the forms and documentation are received after the effective date of the hiring, a retroactive rate adjustment shall be made back to the effective date of employment.

(6) Nursing facilities shall only be reimbursed once for each of the evening or night shifts covered by professional nurses. If a provider loses either shift coverage after receiving the additional 24-hour nursing reimbursement factor, the costs incurred to come back into compliance shall be reflected in the cost report and per diem rate.

(7) Resident days used in the denominator of the 24-hour nursing reimbursement calculation shall be based on the actual resident days from the last nursing facility financial and statistical report submitted. The resident days shall not be subject to the 85 percent minimum occupancy factor.

(8) The 24-hour nursing reimbursement factor shall be reduced as related expenses are reflected in the cost reports.

(9) The provision for 24-hour nursing reimbursement shall not include the cost of contract labor incurred through the use of nursing pool services or other sources. The intent of the 24-hour nursing provision shall be to reimburse the provider for the cost of the professional nurse hired in an employee/employer relationship. The cost of contract labor for nurses shall be an allowable cost reported in the nursing facility financial and statistical report and subsequently reflected in the per diem rate, subject to upper payment limits.

30-10-29 (3)

(10) The provision for 24-hour nursing reimbursement shall not include the cost of nurses on the day shift.

(c) This provision shall expire for requests received after December 31, 1995.

(d) The effective date of this regulation shall be December 29, 1995. (Authorized by and implementing K.S.A. 1994 Supp. 39-708c, as amended by L. 1995, Ch. 153, Sec. 1; effective, T-86-42, Dec. 18, 1985; effective, T-87-5, May 1, 1986; effective May 1, 1987; amended May 1, 1988; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended May 1, 1991; amended Oct. 28, 1991; amended Nov. 2, 1992; amended Dec. 29, 1995.)

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The narrative explanation of the nursing facility (NF) and NF-Mental Health (NF-MH) reimbursement formula is divided into nine sections. The sections are: Cost Reports, Rate Determination, Retroactive Rate Adjustments, Case Mix Payment System, Reimbursement Limitations, Real and Personal Property Fee, Incentive Factor, Inflation Factors and Rate Effective Date.

COST REPORTS

The Nursing Facility Financial and Statistical Report (MS 2004) is the uniform cost report. It is included in Exhibit A-5. It organizes the commonly incurred business expenses of providers into four reimbursable cost centers (administration, plant operating, room and board, and health care). Ownership costs (i.e. mortgage interest, depreciation, lease and amortization of leasehold improvements) are reported but reimbursed through the real and personal property fee. There is a non-reimbursable/non-resident related cost center so that total operating expenses can be reconciled to the providers accounting records.

All cost reports are desk reviewed by agency auditors. Adjustments are made, when necessary, to the reported costs in arriving at the allowable historic costs for the rate computations.

Calendar Year End Cost Reports: All providers not on a projected rate or in the first year of operation are required to file the uniform cost report on a calendar year basis. The requirements for filing the calendar year cost report are found in Exhibit A-5.

When a non arms length change of provider takes place or an owner of the real estate assumes the operations from a lessee, the facility will be treated as an on-going operation. In this situation, the related provider or owner shall be required to file the calendar year end cost report. The new operator or owner is responsible for obtaining the cost report information from the prior operator for the months during the calendar year in which the new operator was not involved in running the facility. The cost report information from the old and new operators shall be combined to prepare a 12 month calendar year end cost report.

Projected Cost Reports: The filing of projected cost reports are limited to: 1) Newly constructed facilities; 2) Existing facilities new to the program; 3) New providers when the rate of the previous provider places the residents care at risk and the rate is less than the statewide average; or 4) A provider re-entering the program who has not actively participated or billed services for 24 months or more. The requirements are found in Exhibit A-5. **NOTE: Effective December 29, 1995, the provision for a new provider to file a projected cost report in accordance with number 3 above is revoked.** The projected cost report is desk reviewed by agency auditors. Rates from the projected cost reports are subject to upper payment limits.

Historical Cost Report Covering Projected Cost Report Period Or The First Year of Operation of a New Provider: The cost report requirements are found in Exhibit A-5.

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There are add-ons to the allowable per diem rate. The add-ons consist of the incentive factor, the real and personal property fee, and the 24 hour nursing factor. The incentive factor and real and personal property fee are explained in separate sections of this exhibit. The 24 hour nursing factor is explained in Exhibit A-18. **NOTE: The provision for the 24 hour nursing factor expires for requests received after December 31, 1995.** The add-ons plus the allowable per diem rate equal the total per diem rate.

RETROACTIVE RATE ADJUSTMENTS

Retroactive adjustments, as in a retrospective system, are made for the following conditions:

One, a retroactive rate adjustment and direct cash settlement is made when an audit, by the agency, determines that the historic cost report data used to determine the prospective payment rate is in error. The prospective payment rate period is adjusted for the audit corrections.

Two, when a projected cost report is approved to determine an interim rate, a settlement is made after a historic cost report is filed for the same period.

And three, when a new provider, through an arms-length transaction, is reimbursed the rate of the prior provider and files a historic cost report for the first 12 months of operation, a settlement is made based on the difference between the interim rate and the rate from the historic cost report. Please note the change below on January 3, 1994.

All settlements are subject to upper payment limits. A provider is considered to be in "projection status" when they are operating on a projected rate or the rate of the old provider and they are subject to the retroactive rate adjustment.

Effective January 3, 1994:

New providers, on or after January 3, 1994, shall not be considered to be in "projection status" when they assume the rate of a previous provider. There will be no retroactive settlement for the first 12 months of operation. The rate effective date for the first historical cost report will be the first day of the month following the cost report period. Rates initially paid after the effective date of the rate based on the first historical cost report will adjusted to the new rate.

For example, a new provider is licensed and certified on March 1, 1994. They assume the rate from the previous provider. They will file the first historic cost report for the period from March 1, 1994 through February 28, 1995.

There will be no settlement for the period from March 1, 1994 through February 28, 1995. The rate effective date from the first historical cost report will be March 1, 1995. Since there is a delay in submitting the cost report and having a rate established, there will be a retroactive rate adjustment from March 1, 1995, until the rate is given to the fiscal agent for payment.

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Only providers filing projected cost reports for interim rates will have a retroactive settlement for the historical cost report covering the projected period.

CASE MIX PAYMENT SYSTEM

Kansas is one of four States involved in the national Multistate Nursing Facility Case Mix and Quality Demonstration Project. The case mix payment system was partially implemented in Kansas on January 1, 1994. The case mix rate calculation process will follow a process similar to that used under the current system. However, under the case mix system, the Health Care cost center upper payment limit will be adjusted by a facility average case mix index (CMI).

The theory behind a case mix payment system is that the characteristics of the residents in a facility rather than the characteristics of the facility should determine the payment rate. The idea is that certain resident characteristics can be used to predict future costs to care for residents with those same characteristics. For these reasons, it is desirable to use the case mix classification for each facility in adjusting provider rates.

Providers are required to submit to the agency the uniform assessment instrument for each resident in the facility. In Kansas, the Minimum Data Set Plus (MDS+) is the uniform instrument. The MDS+ assessments have been maintained in a computer data base.

Each resident's case mix classification will be determined using the Resource Utilization Group, Version III (RUG III) classification system and the most current MDS+ assessment, for the appropriate time period, in the data base for this resident. From this classification, the numeric value or CMI will be determined. Resident assessments that cannot be classified will assigned the lowest CMI for the State.

Once each resident has been classified, a case mix normalization process will be performed annually. The purpose of this process is to set the mean CMI for the State to a value of one (1). In order to accomplish this calculation, the case mix indices for all residents in the State are totalled and divided by the number of residents. The value determined in this calculation will then be divided into each resident's CMI. This will result in the Table showing the normalized numeric value for each RUGs classification. See Exhibit C-2, Page 11. The average CMI for the State will equal one (1).

Now that each resident has been assigned a normalized CMI, the facility average CMI can be calculated. The facility average is determined by adding the CMI for each resident and then dividing by the number of residents.

The next step in the case mix system is to set the limit for the Health Care cost center. This process is slightly different than the method used to set limits for the other cost centers. The base limit will be the upper limit for a case mix of one (1), the statewide average.

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Each facility will have its unique Health Care cost center limit. In theory, each facility's cost for resident care is directly related to its CMI. Because of this assumption, one would expect providers caring for residents needing heavier care to incur higher costs. Arraying the facilities' costs and setting limits without adjusting the case mix would result in a less appropriate rate calculation.

Determining the case mix allows the agency to array the facilities' costs and set limits with costs that should be more comparable. The first calculation is to determine what each facility's cost would be at a case mix of one. The technique of adjusting costs for case mix is known as neutralizing the costs.

Neutralizing costs is done by dividing each facility's per diem costs by its normalized facility average CMI. The CMIs used to normalize the Health Care cost will be the most current MDS+ assessment in the database as of the last day of the cost report period. This date is used to match as closely as possible the CMI to the time the costs were incurred. When this set of calculations is complete, the neutralized per diem costs are then arrayed and the base upper limit for the Health Care cost center will be calculated using the methodology described for the current system.

Neutralized costs are arrayed weighted by resident days. The median cost is determined. The upper limit is calculated by multiplying the day weighted median by the appropriate add-on percentage.

Each facility's unique upper limit is calculated by multiplying the base limit just established by that facility's normalized CMI. For example, if the normalized case mix index of one (1) results in a base limit of $40, a facility with a CMI of .9 would have a Health Care cost center upper payment limit of $36 ($40 x .9). Likewise, a provider with a CMI of 1.1 would have an upper limit of $44 ($40 x 1.1). The provider would be reimbursed the lower of their inflated Health Care per diem cost or their facility specific, CMI adjusted, upper payment limit.

Rates will be adjusted quarterly for changes in a facility's average CMI. Since the health care allowance is based on the lower of costs or the limit, not all facilities will receive a quarterly rate change. A detailed listing of the computation for the rate change and the CMI listing will be sent to the provider.

Case Mix Implementation January 1, 1994:

The case mix payment rate was phased in for dates of service from January 1 through June 30, 1994. The provider received 50% of the rate under the previous system and 50% of the rate under the case mix methodology. There was a "hold harmless" provision for each provider who experienced a rate reduction based on the case mix adjustment for service days from January 1 through June 30, 1994. The rate from the previous methodology was continued if the case mix adjusted rate was less.

Case Mix System Beginning July 1, 1994:

The case mix payment system was fully implemented on July 1, 1994. The rates were no longer adjusted for the phased-in period. Providers received 100% of the case mix adjusted rate. The "hold harmless" provision was eliminated.

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REIMBURSEMENT LIMITATIONS

Period:

The upper payment limits are in effect from July 1st through June 30th, unless otherwise specified by a State Plan amendment.

Upper Payment Limitations:

There are two types of upper payment limits. One is the owner/related party/administrator/co-administrator limit. The other is the cost center limits. Each will be described.

Owner/Related Party/Administrator/Co-Administrator Limit:

Since salaries and other compensation of owners are not subject to the usual market constraints, specific limitations are placed on the amounts reported. First, amounts paid to non working owners and directors are not an allowable cost. Second, owners and related parties who perform resident related services are limited to a salary chart based on the Kansas Civil Service classifications and wages for comparable positions. Owners and related parties who provide resident related services on less than a full time basis have the compensation limited by the percent of their total work time to a standard work week. A work week is defined as 40 hours. The owners and related parties must be professionally qualified to perform services which require licensure or certification.

The compensation paid to owners and related parties shall be allocated to the appropriate cost center for the type of service performed. Each cost center has an expense line for owner/related party compensation. There is also a cost report schedule titled "Statement of Owners and Related Parties". This schedule requires information concerning the percent of ownership (if over five percent), the time spent in the function, the compensation, and a description of the work performed for each owner and/or related party. Any salaries reported in the Plant Operating, Room and Board or Health Care cost centers in excess of the Kansas Civil Service based salary chart are transferred to the administrative cost center where the excess is subject to the Owner/Related Party/Administrator/Co Administrator per diem compensation limit.

The Schedule C is an array of non owner administrator and co-administrator salaries. The schedule includes the most current historic cost reports in the data base from all active nursing facility providers. The salary information is not adjusted for inflation. The per diem data is calculated using an 85% minimum occupancy level for those providers in operation for more than twelve months. The Schedule C for the owner/related party/ administrator/ co-administrator per diem compensation limit is the first schedule run during the annual limitation setting.

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The final results of the Schedule B run are the median compilations. These compilations are needed for setting the upper payment limit for each cost center. The median for each cost center is weighted based on total resident days. The upper payment limits will be set using the following:

Administration	115% of the median
Plant Operating (Portion of Property)	130% of the median
Room and Board	130% of the median
Health Care	125% of the median

The overall Property limit requires additional explanation. The implementation of the real and personal property fee (property fee), effective January 1, 1985, revised the method of determining the property limit. Ownership costs (interest, depreciation, lease or amortization of leasehold improvements) are no longer included in the allowable cost when determining the Medicaid rate. The methodology of the overall property limit needed to be revised after the ownership costs were excluded.

Due to the implementation of the property fee, the calculation methodology of the Total Property cost limit has been revised such that changes in ownership (and resulting increases in ownership costs) after 7/18/84 are not recognized in setting new limits. The change in methodology essentially holds the ownership cost portion of the property limit, effective 10/1/84, constant. The revised methodology only allows for relative changes in the plant operating costs to influence the total Property cost limit.

The calculation of the Total Property cost limit is as follows:

Plant Operating Per Diem Limit from Current Data Base
Minus: Plant Operating Per Diem Limit from Prior Data Base
Equal: Incremental Change in Total Plant Operating Limit
Add: Total Property Cost Limit from Prior Limitation Period
Equal: Total Property Cost Limit for New Limitation Period

The skilled nursing facilities and intermediate care facilities became nursing facilities on October 1, 1990. The Property cost limit, using the incremental change in Plant Operating costs, was based on the Property cost limit from the 10/1/84 data base for skilled facilities. The incremental changes in the Plant Operating costs and the subsequent change in Property cost limits are now determined from the combined Nursing Facility data base.

The property fee resulted in a calculation of a provider specific plant operating limit. The Total Property limit is reduced, on a provider specific basis, by the amount of the property allowance included in the property fee. In this manner, the non-ownership costs are limited by a cost center limit that excludes the ownership cost portion of the Medicaid rate, or the property allowance. The following is the calculation of the Plant Operating Limit:

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Total Property Cost Limit for Limitation Period
Minus: Property Allowance Included in Property Fee
Equal: Plant Operating Cost Center Limit for Limitation Period

It should be noted that the value factor component of the property fee should not be reduced from the Total Property cost limit to determine the Plant Operating Cost Center Limit. The property fee is explained in greater detail in the following section of this exhibit.

Case Mix Adjustment Effective 01/01/94:

The upper payment limit for the Health Care cost center limit will be determined based on the case mix adjustment. This adjustment is explained in detail in the Case Mix Payment System section of this narrative.

REAL AND PERSONAL PROPERTY FEE

The real and personal property fee (property fee) was implemented, effective January 1, 1985, pursuant to Kansas Administrative Regulation 30-10-25. It was implemented as a response to the Deficit Reduction Act of 1984 regarding re-valuation of assets due to a change in ownership. The property fee satisfies this requirement in that it is the capital reimbursement portion of the Medicaid rate and does not change due solely to a change in ownership. The property fee is facility specific and is in lieu of all depreciation, mortgage interest, lease and amortization of lease expense. The actual ownership costs used to develop the property fee were from the latest cost report for each provider that the agency had processed through July, 1984.

The two components of the property fee are the property allowance and the property value factor. An explanation of each of these follows.

Property Allowance: The four line items of ownership cost (mortgage interest, depreciation, lease and amortization of lease expenses) were added together and divided by resident days to arrive at the ownership cost per diem for each provider. The 85% minimum occupancy rule was imposed on all providers who had been in operation for over 12 months. The ownership per diem cost was reduced proportionately for each provider who had total property costs in excess of the 85th percentile limit on the Property Cost Center Limit. This adjustment to the ownership per diem cost was based on the ratio of ownership costs to total property costs, multiplied by the property costs in excess of the cost center limit. The ownership per diem cost minus this adjustment (if any) resulted in the property allowance.

Property Value Factor: The property allowances for all providers were arrayed by level of care and percentiles established. These percentiles became the basis for establishing the property value factor. The five different groupings developed from each array are as follows:

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The Schedule C is used to set the per diem limitation for all non owner administrator and co-administrator salaries and owner/related party compensation in excess of the civil service based salary limitation schedule. The per diem limit for a 50 bed or larger home is set at the 90th percentile on all salaries reported for non owner administrators and co-administrators. A limitation table is then established for facilities with less than 50 beds. This table begins with a reasonable salary per diem for an administrator of a 15 beds or less facility. A linear relationship is then established between the compensation of the administrator of the 15 bed facility and the compensation of the administrator of a 50 bed facility. The linear relationship determines the per diem limit for the facilities between 15 and 50 beds.

The per diem limit applies to the non owner administrators and co-administrators and the compensation paid to owners and related parties who perform an administrative function or consultant type of service. The per diem limit also applies to the salaries in excess of the civil service based salary chart in other cost centers that are transferred to the administrative cost center.

Cost Center Limits:

The Schedule B computer run is an array of all per diem costs for each of the four cost centers-Administration, the Plant Operating portion of Property, Room and Board and Health Care. The schedule includes the most recent historic cost report in the data base from all active nursing facility providers. Projected cost reports are excluded from the data base.

The per diem expenses in each cost center are subject to the 85% minimum occupancy rule for providers reporting costs for the 13th month of operation and after. All previous desk review and field audit adjustments are considered in the per diem expense calculations. The costs are adjusted by the owner/related party/ administrator/co-administrator limitations.

Prior to the Schedule B arrays, the cost data on certain expense lines is adjusted for historical and estimated inflation, where appropriate. This will bring the costs reported by the providers to a common point in time for comparisons. The historic inflation will be based on the Data Resources, Inc. National Skilled Nursing Facility Market Basket Index (DRI Index) for the cost center limits effective July 1st. The historic inflation factor will adjust costs from the midpoint of each providers cost report period to the latest quarterly DRI Index for the Schedule B processing.

The estimated inflation factor will be also be based on the DRI Index. Determination of the estimated inflation factor will begin with the quarter the historic inflation ends. It will be continued to the midpoint of the payment limitation period (December 31st).

Certain costs are exempt from the inflation application when setting the upper payment limits. They include administrators and co-administrator salaries, owner/related party compensation, interest expense, and real and personal property taxes.

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Group #	Percentile Ranking	Add-On Percent
1	-0- through 25th Percentile	45%
2	26th through 50th Percentile	15%
3	51st through 75th Percentile	7.5%
4	76th through 85th Percentile	5%
5	86th through 100th Percentile	0%

Once the percentile groups were established, a weighted average property allowance was calculated for each group. This average property allowance was then multiplied by the add-on percentage to arrive at the property value factor for each group. This add-on percentage is inversely related to the percentile ranking. That is, the lower the percentile ranking, the higher the add-on percentage. The property value factor for each percentile group was then assigned to each provider within that group.

There are two value factor arrays. One array is for the Medicare skilled nursing facilities. The other is for nursing facilities which are not certified as Medicare skilled facilities. The value factor is determined based on the classification of the nursing facility and by using the applicable array.

The applicable array applies to the certification of the facility at the time the property fee is established. The value factor does not change with a change in certification. However, if a property fee changes due to a "rebasing", then the value factor is based on the array for which the facility is certified at the time the rebasing is effective.

There are two provisions for changing the property fee. One is for a "rebasing" when capital expenditure thresholds are met ($25,000 for homes under 51 beds and $50,000 for homes over 50 beds). The original property allowance remains constant but the additional factor for the rebasing is added. The property fee rebasing is explained in greater detail in Exhibit A-14. The other provision is that an inflation factor may be applied to the property fee on an annual basis.

INCENTIVE FACTOR

The incentive factor is a per diem add-on ranging from zero to fifty cents. It is based on the per diem cost of the Administration cost center and the Plant Operating cost center less the real and personal property taxes expense line. The per diem allowance for these two cost centers less property taxes is determined before the owner/related party/administrator co-administrator limitation is applied.

The incentive factor is designed to encourage economy and efficiency in the administrative and plant operating cost areas. Property taxes were excluded since the provider has little control of the cost. There is an inverse relationship between the incentive factor and the per diem cost used to determine it. The higher the per diem cost, the lower the incentive factor.

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Narrative Explanation of Nursing Facility Reimbursement Formula

The Schedule E is an array of the per diem costs that are used to determine the incentive factor. The schedule includes the costs from the most recent historical cost report for all active providers. No projected cost reports are included. The per diem costs are based on the 85% occupancy rule. The costs are not adjusted for inflation.

The Schedule E summarizes all expense lines from the Administration cost center and the Plant Operating cost center, less property taxes. The ownership costs are excluded from the array so that both older facilities (with relatively lower ownership costs) and newer facilities (with relatively higher ownership costs) can benefit from the incentive factor through efficient operations. The Room and Board and Health Care cost centers are excluded from the incentive factor calculation so that providers are not rewarded for cost efficient operations with regard to costs that may jeopardize the direct care of the residents.

The total per diem costs for administration and plant operating, less property taxes, are arrayed and percentiles established. These percentiles then become the basis for establishing the per diem cost ranges used to determine each providers efficiency factor, consistent with agency policy. The ranges are defined as follows:

Providers Percentile Ranking	Incentive Factor Per Diem
-0- to 30th Percentile	$.50
31st to 55th Percentile	.40
56th to 75th Percentile	.30
76th to 100th Percentile	-0-

INFLATION FACTORS

Inflation will be applied to the allowable reported costs from the calendar year end cost reports for rates effective July 1st. The inflation will be based on the Data Resources, Inc. National Skilled Nursing Facility Market Basket Index (DRI Index). The inflation will be applied from the midpoint of the cost report period to the midpoint of the payment limitation period (December 31st). This annual percentage estimate is used consistently throughout the limitation period.

The DRI Indexes listed in the latest available quarterly publication will be used to determine the inflation tables for the payment schedules processed during the payment limitation period. This will require the use of forecasted factors in the inflation table. The inflation tables will not be revised until the next payment limitation period.

For historic cost report periods ending other than the last month in a quarter, the inflation factor to be used in the calculation will be the factor for the quarter in which the cost reporting period ends. For example, a cost report period ended August 31st, will receive inflation based on the calculation using the September, third quarter, DRI Index forecast. This approach is being used instead of trying to convert a quarterly index into monthly factors.

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Narrative Explanation of Nursing Facility Reimbursement Formula

The table "Inflation For Report Year Ends Prior To 7/1/94" (Exhibit C-2, pages 1) is applied in determining rates with an effective date of July 1. The table "Inflation for Report Year Ends After 7/1/94" (Exhibit C-2, page 2) is applied in determining rates for non calendar year historic cost reports with rate effective date other than July 1.

The inflation factor is applied to all costs except the following:

1) Administrator and Co-Administrator Salaries

2) Owner/Related Party Compensation

3) Interest Expense

4) Real and Personal Property Taxes

RATE EFFECTIVE DATE

Rate effective dates are determined in accordance with Exhibit A-7. The rate may be revised for an add-on reimbursement factor (i.e. rebased property fee or 24 hour nursing), desk review adjustment or field audit adjustment.